WORKERS' COMPENSATION

MANUAL

WORKERS' COMPENSATION MANUAL

This Workers' Compensation Manual is for all Coordinators responsible for reporting workers' compensation claims and any information pertaining to these claims under the Commonwealth of Kentucky Workers' Compensation Self-Insurance Program. The manual is available online or by email. Every Coordinator should make sure all agency personnel working with workers' compensation has this manual available to comply with the WC Program procedures.

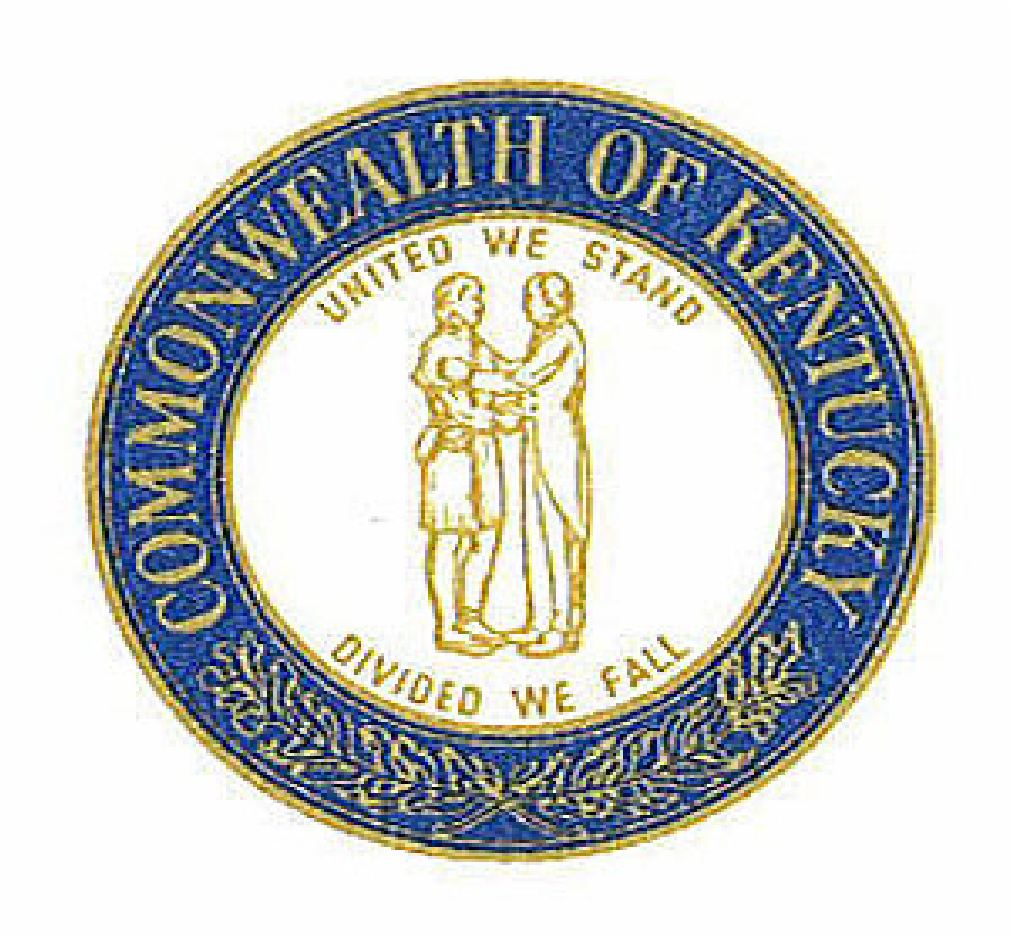
SECTION 1 – ADMINISTRATION

SECTION 2 – BENEFITS

SECTION 3 – PROCEDURES FOR FILING FORMS

APPENDIX

SECTION 1



ADMINISTRATION

SECTION 1 – ADMINISTRATION

WORKERS' COMPENSATION LAW

The Workers' Compensation Law (KRS 342) is designed to compensate employees for loss of earning power due to work-related injuries or disease arising out of and in the course of their employment. This coverage includes:

- Medical
- Temporary Total Disability
- Permanent Partial Disability
- Permanent Total Disability
- Rehabilitation Services
- Death and Burial Benefits

NOTE: Refer to Section 2 for explanation of each type of benefit.

STATE WORKERS' COMPENSATION PROGRAM

On July 1, 1979, the Commonwealth of Kentucky established a Workers' Compensation Self-Insurance Program to be administered by the Personnel Cabinet, Division of Employee Benefits. Claims are processed and reviewed by the State Workers' Compensation Deputy Executive Director along with their third party administrator.

Services provided by the Third Party Administrator include:

- Investigate all reported injuries to establish compensability.
- Payment of benefits.
- Establish loss-cost reserves.
- Arrange expert medical examinations.
- Return injured employees to gainful employment with RTW Program.
- Utilize Managed Care Plan for medical benefits.
- Contact Workers' Comp Deputy Executive Director for authorization of settlements.

ELIGIBILITY

The Workers' Compensation Self-Insurance Program currently covers:

All State employees (except Transportation Cabinet)

Kentucky Community and Technical College System

Volunteer Firefighters

Volunteer Ambulance Personnel

Kentucky Lottery Corporation

The Kentucky Center

Lexington-Fayette County Health Department

Boone County Clerk's Office

Boone County Sheriff's Office

Campbell County Clerk's Office

Campbell County Sheriff's Office

Christian County Clerk's Office

Christian County Sheriff's Office

Daviess County Clerk's Office

Daviess County Sheriff's Office

Hardin County Clerk's Office

Hardin County Sheriff's Office

Fayette County Clerk's Office

Fayette County Sheriff's Office

Jefferson County Clerk's Office

Jefferson County Sheriff's Office

Kenton County Clerk's Office

Kenton County Sheriff's Office

Madison County Clerk's Office

Madison County Sheriff's Office

Pike County Clerk's Office

Pike County Sheriff's Office

Warren County Clerk's Office

Warren County Sheriff's Office

Bluegrass Rape Crisis Center

Lincoln Trail Advocacy and Support Ctr

Big Sandy Area Child Advocacy

Lake Cumberland Children's Advocacy Ctr

State University employees except:

(University of Kentucky

University of Louisville

Eastern Kentucky University

Kentucky State University

Western Kentucky University

Morehead University

Northern Kentucky University)

SECTION 2

BENEFITS

SECTION 2 - BENEFITS

MEDICAL

As of October 1, 2005, the program has elected to utilize a managed care program to provide covered medical benefits.

An employee who sustains a **compensable** injury or disease is entitled to immediate and continuing medical treatment at the expense of the employer. An employee **should never** use their health insurance when they are seeking treatment under workers' compensation. The employer shall pay for the cure and relief from the effects of an injury or occupational disease as may reasonably be required at the time of the injury and thereafter during disability. This treatment includes:

- Medical
- Surgical and hospital treatment
- Nursing
- Medical supplies, surgical supplies and appliances

Requiring employees to make co-payments for treatment of work-related injuries is unlawful. Likewise, medical providers **may not** engage in "balance billing" by charging employees separately for amounts in excess of those set forth in the medical fee schedule.

TEMPORARY TOTAL DISABILITY BENEFITS

An employee who sustains a compensable injury or disease and is unable to work after a waiting period of seven (7) days is entitled to income benefits which are calculated at:

- 66 2/3 percent of his average weekly wage, but no more than one hundred percent (100%), or less than twenty percent (20%) of the State's average weekly wage.

The weekly benefits for a 2005 injury are:

- Maximum $607.23
- Minimum $121.45

Maximum and minimum benefits are determined by the Workers' Compensation Board, and subject to change every year.

Entitlement to these benefits begins on the eighth (8th) day of disability. The first seven-(7) days of disability are payable only if total disability lasts 15 days or more. "Days of disability" refers to those days when a doctor has deemed an employee unable to work because of a work-related injury or disease. These "Days of Disability" do not refer only to consecutive scheduled workdays, but also includes weekends and holidays.

Temporary total disability benefits usually continue until an employee reaches maximum medical improvement, is released to return to work by a physician, or returns to work -- whichever occurs first.

PERMANENT PARTIAL DISABILITY

An employee who has recovered as much as he/she will from an occupational injury or disease, but still has some permanent impairment which results in a permanent but partial loss of wages or wage earning capacity, is entitled to benefits calculated as follows:

- When an employee **does** return to work at an equal or greater wage, that employee will receive 66 2/3 percent of his/her average weekly wage, but not more than 75 percent of the State's average weekly wage, multiplied by his/her percentage of impairment caused by the injury or disease.

The weekly benefits for a 2005 injury are:

- Maximum $455.42
- Minimum $ None

Maximum and minimum benefits are determined by the Workers' Compensation Board and are subject to change every year.

PERMANENT TOTAL DISABILITY

An employee who has reached maximum medical improvement but still has permanent impairment and restrictions, which prevent him from performing regular employment of the type he was doing before his injury, is entitled to benefits calculated at:

- 66 2/3 percent of his average weekly wage, but not more than one hundred percent (100%) or less than twenty percent (20%) of the State's average weekly wage.

The weekly benefits for a 2005 injury are:

- Maximum $607.23
- Minimum $121.45

Maximum and minimum benefits are determined by the Workers' Compensation Board, and subject to change every year.

DEATH AND BURIAL BENEFITS

If death of employee occurs within four (4) years from date of injury as a direct result of the injury, a lump sum payment to estate will be made, from which burial expenses are to be paid.

WORKERS' COMPENSATION TEMPORARY TOTAL DISABILITY CHECKS

According to 101 KAR 2:140 Section 4(2), the employee's absence due to illness or injury for which Workers' Compensation benefits are received for lost time, sick leave may be utilized to the extent of the difference between such benefits and the employee's regular salary.

Under no circumstances should an employee receive more pay than his normal salary for that period. The payroll officer is responsible to ensure that this does not occur. Upon receipt of the Workers' Compensation check, the payroll officer would determine if the employee was entitled to receive the check by the following guidelines:

1. If the employee utilized leave for the entire period, the Workers' Compensation check would be signed over to the State to reinstate leave. To determine the number of hours to reinstate, the payroll officer would divide the Workers' Compensation check by the employee's hourly wage rate and reinstate that number of hours to the employee's leave balance.

2. If the employee was placed on leave without pay for the entire period, the employee would be entitled to receive the entire Workers' Compensation check.

3. If the employee utilized leave and was also placed on leave without pay for a portion of the period, the Workers' Compensation check and the employee's payroll check would be added together to determine if the total would exceed the employee's normal salary.

    a. If the two (2) checks do not exceed the employee's normal salary, the employee is entitled to receive both checks.

    b. If the two (2) checks exceed the employee's normal salary, the amount in excess of the normal salary must be paid back to the State to reinstate leave. The amount in excess is divided by the employee's hourly wage to obtain the number of hours of leave to reinstate to the employee's leave balance.

REHABILITATION

An employee who sustains an injury under Workers' Compensation shall be entitled to prompt medical rehabilitation services for whatever period of time necessary to accomplish physical rehabilitation goals, which are feasible, practical, and justifiable. If he is unable to perform work which he/she has previous training or experience, he shall be entitled to such vocational rehabilitation services, including retraining and job placement.

RTW PROGRAM

The Personnel Cabinet's Workers' Compensation Branch has a Certified Rehabilitation Counselor to implement a RTW Program with all employees off on Temporary Total Disability. Responsibilities of the RTW Program include:

- Working with each agency covered under the Workers' Compensation Program in coordinating an early return to work for employees with a work-related injury designed to minimize loss time from work.
- Working with employers to modify the work environment to meet restrictions that are ordered from the doctors and to assist employers with providing modified duty.
- Coordinating rehabilitation nurses and claim adjusters to determine the extent of the restrictions, length of projected recovery and to work with employers to provide a successful return to modified duty and full duty work
- Work with the State Safety Director and Workers' Compensation Administrator to prevent injuries and to provide proactive management of workers' compensation claims.

It is extremely important that each agency make an extra effort to return injured workers to the job. In 1990, the Americans with Disabilities Act (ADA) was enacted and it is becoming more important than ever to meet the employee's restrictions and provide job modifications for employees with disabilities.

SECTION 3

PROCEDURES FOR FILING FORMS

SECTION 3 - PROCEDURES AND FORMS

EFFECTIVE 8/15/2005: CCMSI, Inc will be the third party administrator for the Commonwealth. CCMSI toll free number is 1-866-320-8456, Fax: 502-426-9516. The Commonwealth will begin utilizing a Managed Care Plan (MCP) 10/1/2005 per KRS 342-020, for workers' compensation medical benefits. This is a health care system that employs a network of "gatekeeper" physicians who provide referrals to specialists when needed. Injured employees must treat within the MCP with some exceptions for emergency care and may seek a second opinion "out-of-network" when surgery is recommended. Toll free number for Concentra/MCP is 1 866-361-6899. The employer is responsible for posting and distributing information regarding the MCP to their employees.

FIRST REPORT OF INJURY OR ILLNESS (IA-1)

For Workers' Compensation benefits, there is only one requirement of the employee--to "notify his/her supervisor as soon as practicable after happening thereof" (KRS 342-185). When a supervisor has knowledge of a work-related injury or illness or *alleged injury or illness* to one of his employees, it is his/her responsibility to obtain all pertinent information and complete a First Report of Injury (IA-1) form. Effective August 15, 2005 the Workers' Compensation Program will begin implementation of a new procedure for processing the First Report of Injury (IA-1). The supervisor responsible will be trained to enter the IA-1 online for submission directly to the Workers' Compensation Branch. Reporting will be accessible at any time. For employers that have limited internet access, the Workers' Compensation Branch call in line will continue to be available. The reporting time is Monday through Friday from 8:30 AM to 4:30 PM EST at either (502) 564-2226 or (502)564-2307 or toll free at 1-888-860-0302. Any questions regarding the status of a Workers' Compensation claim should be addressed at (502) 564-6846**.** If the injury occurs during the evening hours or on the weekend the injury may be reported immediately online or at the beginning of the next working day. Copies of the IA-1 will be sent to your agency for documentation in your records. Even if the employee does not plan to visit a doctor, it is still important to report a First Report of Injury (IA-1). This must be completed "within three (3) working days", (KRS 342.038), after the injury due to the time requirement on making the first payment to the employee. This requirement cannot be met if the injury report is not received promptly. Failure to comply with this statute can result in a fine being levied of up to $1,000.00 for each occurrence. The First Report of Injury (IA-1) must be submitted or called in by the supervisor immediately after notification of injury. The First Report of Injury (IA-1) must be complete and thorough. Give specifics: i.e., right arm or left arm, upper back or lower back, etc. Each question must be answered completely, accurately.

It is unlawful to knowingly make a misrepresentation of a material fact to obtain workers' compensation benefits. Likewise, it is unlawful to misrepresent important facts to avoid responsibility under the law. Through its Insurance Fraud Unit, the Department of Insurance actively investigates and prosecutes workers' compensation fraud. Violations may result in civil fines and criminal procedures.

For a copy of the First Report of Injury (IA-1) form, please see **Attachment A**.

First Report of Injury (IA-1) Signature Page

All employees reporting a work related injury must sign this signature page when the submitted form is completed. By signing this page, employees acknowledge they understand it is unlawful to file a fraudulent workers' compensation claim.

MEDICAL WAIVER AND CONSENT FORM (FORM 106)

Form 106 was adopted in April 1986 and must be completed by the employee and submitted along with the First Report of Injury (IA-1). This form allows workers' compensation to obtain medical documentation on the employee's injury. The employer is entitled to a signed release of medical information when an employee reports a work-related injury or disease. **Any medical bills received by the employer should be sent to the Workers' Compensation Program's third party administrator: CCMSI, Inc. P O Box 43909 Louisville Kentucky 40253, 1 866-320-8456.**

Form 106 was recently revised in April 2003, to assist health care providers to comply with the federally mandated Health Insurance Portability and Accountability Act (HIPPA). For a copy of the Medical Waiver and Consent Form please see **Attachment B**.

WORKERS' COMPENSATION TEMPORARY PRESCRIPTION SERVICES ID FORM –
May be given to injured employees at time of injury to fill related prescriptions. This form MUST BE PRESENTED to your pharmacist when you fill your initial prescription(s). **ATTACHMENT C.**

LOSS TIME AND RETURN TO WORK FORM

Form WCF-1 must be completed by the supervisor and submitted **immediately** when one of the following occurs in order for employees to receive their lost time benefits in a timely manner:

- When an injured employee loses time from work due to a work-related injury.
- When an injured employee returns to work.
- At the time of death of an injured employee.

For a copy of the Loss Time and Return to Work Form (WCF-1), please see **Attachment D.**

SICK LEAVE - WORKERS' COMPENSATION FORM

According to 101 KAR 2:140 Section 4 (2), the employee's absence due to illness or injury for which Workers' Compensation benefits are received for lost time, sick leave may be utilized to the extent of the difference between such benefits and the employee's regular salary.

To use sick leave for a Workers' Compensation injury, the employee must assign his/her Workers' Compensation check to the agency by completing a Sick Leave - Workers' Compensation form prior to receiving sick leave. This form **must be signed** by the employee, witnessed, and forwarded to the payroll officer for their records. For a copy of the Sick Leave - Workers' Compensation Form (WCF-2), please see **Attachment E.**

REPORT OF MEDICAL STATUS FORM

The Report of Medical Status Form (WCF-5) was adopted by the Workers' Compensation Office in October 1994 and should be issued at the time the First Report of Injury (IA-1) is completed or as soon as practicable, if the employee intends to seek medical treatment. This form must be issued to the employee prior to their first doctor's appointment. The employer is responsible for completing the first section of the form titled, "To Be Completed By Employer". The physician will then complete the remaining sections of the form and return it to the employee. Once the physician has completed the form, the employee should return the completed form to their employer. **The employer will then mail the completed form to the Workers' Compensation Office.** It is imperative that each injured employee receive this form **before** they go to the doctor's office. With the proper completion of this form, this office can better monitor the treatment of each injured employee. For a copy of the Report of Medical Status Form (WCF-5), please see **Attachment F**.

REIMBURSEMENT FORM - For a copy of the Request for Payment For Services or Reimbursement Form 114, please see **Attachment G.**

AVERAGE WEEKLY WAGE FORM – This form should be completed by the employer when requested and **includes all paid leave**. In most instances, an employee's AWW is calculated by using the highest wages paid during a 13 week period in the year before the injury occurred. If the employee has not worked 52 weeks, a "like employee's" wages should be used. Overtime is included, but only at the regular hourly wages. These earnings for the highest quarter are then divided by 13 and the result is the employee's AWW. Questions regarding this form should be forwarded to the Workers' Compensation Branch. For a copy of the Weekly Wage Form, please see **Attachment H**

NOTICE OF DESIGNATED PHYSICIAN FORM - As soon as possible after the work-related injury occurs, the employee should obtain necessary medical services. The employee may choose the treating physician and can change that selection one time, no questions asked. If the employer has entered into an authorized managed care program, the employee must choose from among the participating medical providers. Employees must notify the employer and insurance carrier of the physician choice.
The employer or insurance carrier should deliver to the employee a physician designation (Form 113) and identification card once it is known that the employee requires continuing medical care. **ATTACHMENT I**

COMMONWEALTH OF KENTUCKY

WORKERS' COMPENSATION NOTICE

Employees of this business are covered by the Kentucky Workers' compensation Act (KRS Chapter 342). Conspicuous posting of the Notice is required by law. Effective 8/15/2005:

Employer Name:	Commonwealth of Kentucky
Address:	200 Fair Oaks Lane, Room 511 Frankfort, KY 40601
Workers Compensation TPA:	CCMSI, Inc.
Policy Number:	Self-Insured
Address:	P O Box 43909 Louisville, KY 40253
Telephone:	(866) 320-8456
Contact Person:	Mary Carney

EMPLOYEES: IF INJURED – NOTIFY your supervisor IMMEDIATELY; when possible Notice should be in writing. FAILURE to notify your supervisor could result in denial of benefits. OBTAIN MEDICAL CARE. Your employer must pay for ALL NECESSARY MEDICAL CARE to treat a workplace injury. If the employer is enrolled in an approved Managed Care Plan employee selection of physicians is LIMITED to the Approved Provider Network, except in certain emergencies. FOR INJURIES REQUIRING CONTINUING CARE the EMPLOYEE MUST DESIGNATE A TREATING PHYSICIAN, a Form 113 will be furnished by your employer or its insurance carrier for this purpose.

This employer <u>is</u> participating in a Managed Care Plan for medical care effective 10/1/2005. For information regarding participating physicians call 1-866-361-6899.

DISABILITY BENEFITS to replace wages lost due to a workplace injury are payable under the Workers Compensation Act after seven (7) days of disability. A CLAIM MUST BE filed with the Office of Workers Claims WITHIN TWO YEARS of the date of injury, or last payment of temporary total disability benefits for continuing benefits.

NEED ASSISTANCE? Contact your employer's claim representative or Workers' Compensation Branch, Personnel Cabinet at 1-502-564-6847. If your question about workers' compensation is not resolved, call THE KENTUCKY DEPARTMENT OF WORKERS' CLAIMS AT 1-800-554-8601 to speak to an Ombudsman or Workers Compensation Specialist.

EMPLOYER SUPERVISORS – NOTIFY MANAGEMENT IMMEDICATELY OF ALL INJURIES SO THAT A TIMELY REPORT CAN BE MADE AS REQUIRED BY LAW.

AN EQUAL OPPORTUNITY EMPLOYER M F D

Jurisdiction | Jurisdiction Claim Number

Insured Report Number

Employer's Location Address (if different) | Location No.

Code | Employer FEIN | Phone No.

rrier (Name, Address & Phone Number)

Policy Period

To

☐ Check if self insured

Claims Admin (Name, Address & Phone Numbe

rrier FEIN | Policy Number or Self-Insured Number | Administrator FEIN

ent Name & Code Number

gal Name (Last, First, Middle) | Date of Birth | Social Security Number | Date Hired | State of Hire

dress (Incl. Zip)

Sex: ☐ Male ☐ Female ☐ Unknown

Marital Status: ☐ Unmarried/ Single/Div. ☐ Married ☐ Separated ☐ Unknown

Occupation/Job Title

Employment Status

one | No. of Dependents | NCCI Class Code

ge Rate | ☐ Day ☐ Week | ☐ Month ☐ Other | # Days Worked/WK | # Hrs Worked per Day | Full Pay for Date of Injury? ☐ Yes ☐ | Did Salary Continue? ☐ Yes ☐

ne Employee gan Work | ☐ AM ☐ PM | Date of Injury or Illness | Time Occurred | ☐ AM ☐ PM | Last Work Date | Date Employer Notified | Date Disabilit Began

ployer Contact Name/Phone Number | Type of Illness/Injury | Part of Body Affected

Injury/Illness Exposure Occur on Employer's emises? Yes ☐ No ☐ | Type of Illness/Injury Code | Part of Body Affected Code

partment or location where accident or illness exposure occurred | All Equipment, Materials, or Chemicals Employee was using when accident or illness exposure occurred.

ecific Activity the Employee was engaged in when the accident or illness posure occurred. | Work Process the Employee Was Engaged in when accident or illne exposure occurred.

w injury or illness/abnormal health condition occurred. Describe the sequence of events and include any objects or substances t directly injured the employee or made the employee ill. | Cause of Injury Code

te Returned to Work | If Fatal, Date of Death | Were Safeguards or Safety Equipment Provided? ☐ Yes ☐ | Were they used? ☐ Yes ☐

ysician/Health Care Provider (Name & Address) | Hospital (Name & Address)

Initial Treatment
0 ☐ No Medical Treatment
1 ☐ Minor: By Employer
2 ☐ Minor Clinic/Hosp
3 ☐ Emergency Care
4 ☐ Hospitalized > 24 hr.
5 ☐ Future Major Medical/Los Time Anticipated

ness to Accident (Name & Phone Number)

e Administrator Notified | Date Prepared | Preparer's Name & Title | Preparer's Phone Number

1 (2/96) | SEE NEXT PAGE FOR IMPORTANT STATE INFORMATION/SIGNATURE

Applicable in Arkansas

Any person or entity who willfully and knowingly makes any material false statement or representation for the purpose of obtaining any benefit or payment, or for the purpose of defeating or wrongfully decreasing any claim for benefit or payment or obtaining or avoiding worker' compensation coverage or avoiding payment of the proper insurance premium (or who aids and abets for either said purpose), under this chapter shall be guilt of a Class D Felony.

Applicable in California

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payment is guilty of a felony.

Applicable in Connecticut

This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.

Applicable in California

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Applicable in Delaware and Oklahoma

Any person who, knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. The lack of such a statement shall not constitute a defense against prosecution under this section. *Delaware Statutes Regulation: Del #C Section 913(B)

Applicable in Florida

Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company or self-insured program, files any statement of claim containing any false or misleading information is guilty of a felony of the third degree.

Applicable in Idaho

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Applicable in Indiana

A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Applicable in Kentucky and New York

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. In New York, such person shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicable in Michigan

Any person who knowingly and with intent to injure or defraud any insurer submits a claim containing any false, incomplete, or misleading information shall, upon conviction, be subject to imprisonment for up to one year for a misdemeanor conviction or up to ten years for a felony conviction and payment of a fine of up to $5,000.00.

Applicable in Minnesota

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Applicable in Nevada

Pursuant to NRS 686A.291, any person who knowingly and willfully files as statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a felony.

Applicable in New Hampshire

Any person who, with purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

Applicable in New Jersey

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Applicable in Ohio

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer ,submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Applicable in Pennsylvania

Any person who knowingly and with intent to injure or defraud any insurer files a claim containing any false, incomplete or misleading information shall upon conviction, be subject to imprisonment for up to seven years or payment of a fine of up to $50,000.

Applicable in Utah

Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.

EMPLOYEE SIGNATURE:_____

IA-1 (2-95)

FORM 106 **ATTACHMENT B**
ADOPTED JULY 2003

COMMONWEALTH OF KENTUCKY
OFFICE OF WORKERS' CLAIMS
657 CHAMBERLIN AVENUE
FRANKFORT, KY 40601

MEDICAL WAIVER AND CONSENT

I, _____-_____ having filed a claim for workers' compensation benefits, do hereby waive any physician-patient, psychiatrist-patient, or chiropractor-patient privilege I may have and hereby authorize any health care provider to furnish to myself, my attorney, my employer, its workers compensation carrier or its agent, the Division of Workers' Compensation Funds, the Uninsured Employers' Fund, or Administrative Law Judge any information or written material reasonably related to my work-related injury occurring on or about _____ any medical information relevant to the claim including past history of complaints of, or treatment of, a condition similar to that presented in this claim or other conditions related to the same body part. Such information is being disclosed to the purpose of facilitating my claim for Kentucky workers' compensation benefits.

I understand I have the right to revoke this authorization in writing at any time, by sending written notification to each individual health care provider, but such revocation will not have any affect on actions taken prior to revocation. Moreover, inasmuch as KRS 342.020(8) requires a medical waiver to be executed, revocation may result in suspension or delay of the workers' compensation claim.

I understand that no medical provider may condition treatment or payment on whether I sign this medical waiver; however, I further understand that failure to sign this medical waiver may result in suspension or delay of the workers' compensation claim.

I understand that the information used or disclosed pursuant to this medical waiver may be subject to re-disclosure by the recipient. This authorization shall remain valid for 180 days following its execution. A photocopy of the authorization may be accepted in lieu of the original.

The authorization includes, but is not restricted to, a right to review and obtain all copies of all records, x-rays, x-ray reports, medical charts, prescriptions, diagnoses, opinions and courses of treatment.

Signed at _____, Kentucky, this _____ day of _____, 20_____.

_____
Signature of Patient Or Personal Representative

Social Security Number: _____----_____

_____
Witness Signature

_____
Description Of Personal Representative's Authority

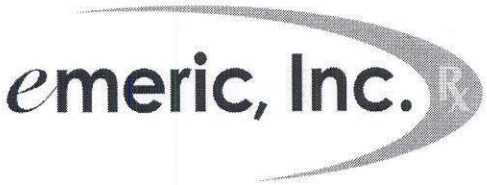
KENTUCKY WORKERS' COMPENSATION AND HIPAA

On April 14, 2003, the federal Health Insurance Portability and Accountability Act [HIPAA] privacy regulation will take effect. This regulation limits the situations in which medical providers may release patient information, unless the information is necessary for the purpose of treatment, payment, or health care operations. Moreover, it is important to note that disclosures for workers' compensation are in most instances exempt from HIPAA privacy requirements. The exact wording is as follows: "A covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation…"

Since HIPAA defers to state law regarding disclosures relating to workers' compensation, it is important for claimants and medical providers to know what Kentucky law requires for disclosure of patient information. An employee who reports a work injury or who files for workers compensation benefits must "execute a waiver and consent of any physician-patient, psychiatrist-patient, or chiropractor-patient privilege with respect to any condition or complaint reasonably related to the condition for which the employee claims compensation." KRS 342.020 (8). Kentucky law further states that once this Form 106 is signed, any health care provider "shall, within a reasonable time after written request by the employee, employer, workers' compensation insurer [or its agent or assignee], special fund, uninsured employers fund, or the administrative law judge, provide the requesting party with any information or written material reasonably related to any injury or disease for which the employee claims compensation."

Once the Form 106 is signed, health care providers may disclose information as set out in Kentucky law. Another section of the regulation allows release of information pursuant to an administrative or judicial order or subpoena, provided that there has been a reasonable effort to notify the injured worker [or his attorney] that such a request has been made. Should there be questions regarding disclosures pursuant to this form, appropriate legal counsel should be consulted or you can contact the Department of Workers' Claims at 800 554-8601.

ATTACHMENT C



Date:

Name:
Address:
Address:

Re: Name:
Claim Number:

Dear _____:

Commonwealth of Kentucky Personnel Cabinet's contracted workers' comp administrator, CCMSI, has designated Emeric to provide you with a Workers' Compensation prescription program. This program allows injured employees to quickly fill their prescriptions at almost any pharmacy with no out-of-pocket expense, eliminating the wait for reimbursement. To utilize this plan, please follow this simple procedure:

- When your physician dispenses a prescription for medication related to your injury take it to your local pharmacy or any national chain pharmacy.
- You **must** present this letter to the pharmacist with your prescription to enroll in the program. This will provide the information necessary to process your prescription.
- The pharmacist will process your prescription on-line with Emeric.
- Your prescription will be filled at no cost to you. Your insurance company will be billed directly.
- If you currently have a prescription that is due to be refilled; present this letter to your pharmacist at the time you request your refill.

If you have any questions regarding this process, please contact Emeric toll-free at (800) 661-1494 or your workers' compensation adjuster at CCMSI (866) 320-8456.

Please Remove this Portion and Give to the Pharmacy

Pharmacist: Please use the following information to process the prescription. If you have any questions or problems please call the pharmacy help desk at **(800) 661-1494.**

CLAIMANT'S NAME:
PLAN: **Emeric**
MEMBER ID: **SSN/Date of Injury** _____
GROUP : **Commonwealth of Kentucky**

If your local pharmacy is not a participating provider, please have them call 1-800-661-1494 to become a member of our network.

MEMORANDUM

TO: PERSONNEL CABINET
Return-To-Work Program
Room 511, 200 Fair Oaks Lane
Frankfort, Kentucky 40601
502-564-0348
(FAX) 502-564-3524

CONTACT NAME: _____
AGENCY: _____
PHONE NUMBER: _____

SUBJECT: Lost Time and Return to Work Form

DATE: _____

This form must be completed by the supervisor and submitted immediately when one of the following occurs:

1) **When an injured employee begins to lose a full day from work due to a work-related injury.**

2) **When an injured employee returns to modified duty OR full duty work. (This information is important in order to assure that an employee is not over paid.)**

3) **At the time of death of an injured employee.**

NAME OF INJURED _____
(FIRST) (MI) (LAST)

DATE OF INJURY _____

DATE LOSS OF WORK BEGAN _____

DATE INJURED RETURNED TO MODIFIED DUTY WORK _____

DATE INJURED RETURNED TO FULL DUTY WORK _____

COMMENTS: (Notify if death of employee, Employee returned to work with restrictions, returned to only part-time work, returned at different job, etc.)

_____

COMPLETED BY: _____ **OFFICAL TITLE** _____

WCF-1
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ATTACHMENT E

SICK LEAVE - WORKERS' COMPENSATION

NAME: _____

I hereby request payment from my accumulated sick leave while I am off work due to an illness or injury for which workers' compensation benefits are claimed.

I acknowledge that I am not entitled to use sick leave for time off from work due to an illness or an injury for which workers' compensation benefits are claimed except to supplement my workers' compensation benefits and maintain my regular full salary.

I hereby assign my workers' compensation benefits to: (State Agency)
and authorize said agency to receive and hold by workers' compensation check until I endorse said check to the agency.

I may revoke this authority at any time in writing by delivering a copy of the writing to the agency, however, said revocation shall not apply to any workers' compensation check for periods of time in which I have already received sick pay.

This the _____day of _____, 20_____

_____
Signature

_____
Witness

WCF-2
Rev. 2005

ATTACHMENT F

COMMONWEALTH OF KENTUCKY/ CCMSI, INC. - REPORT OF MEDICAL STATUS

Employee Name: (First) (Middle Initial) (Last)	**Date of Injury/Illness:**

Is this Injury/Illness Work Related: ☐ **YES** ☐ **NO**

Diagnosis:

TO BE COMPLETED BY ATTENDING PHYSICIAN - PLEASE CHECK

I saw and treated this patient on _____ and:

☐ **1. Recommend patient return to work with no limitations on _____.**
(Date)

☐ **2. Patient may return to work capable of performing the degree of work checked below with the following limitations:**
Please Note: If limitations are noted a time limit must be indicated in Item #3 below!

PLEASE INDICATE DEGREE OF WORK

☐ **Sedentary Work:** Exerting up to 10 pounds of force occasionally and/or a negligible amount of force frequently to lift, carry, push, pull or otherwise move objects, including the human body. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time. Jobs are sedentary if walking and standing are required only occasionally and all other sedentary criteria are met.

☐ **Light Work:** Exerting up to 20 pounds of force occasionally, and/or a negligible amount of force constantly to move objects. A job should be rated Light Work; (1) when it requires walking or standing to a significant degree; or (2) when it requires sitting most of the time but entails pushing and/or pulling of arm or leg controls; and/or (3) when the job requires working at a production rate pace entailing the constant pushing and/or pulling of materials even though the weight of those materials is negligible. NOTE: The constant stress and strain of maintaining a production rate pace, especially in an industrial setting, can be and is physically demanding of a worker even though the amount of force exerted is negligible.

☐ **Medium Work:** Exerting 20 to 50 pounds of force occasionally, and/or 10 to 25 pounds of force frequently, and/or greater than negligible up to 10 pounds of force constantly to move objects.

☐ **Heavy Work:** Exerting 50 to 100 pounds of force occasionally, and/or 25 to 50 pounds of force frequently, and/or 10 to 20 pounds of force constantly to move objects.

☐ **Very Heavy Work:** Exerting in excess of 100 pounds of force constantly and/or in excess of 50 pounds of force frequently, and/or in excess of 20 pounds of force constantly to move objects.

PLEASE INDICATE LIMITATIONS

Restricted Activities	May Perform Activity		
	Occasionally	Frequently	Continuous
% of Assigned Shift	(1-33%)	(34-66%)	(67-100%)
Stooping	☐	☐	☐
Bending	☐	☐	☐
Lifting	☐	☐	☐
Reaching	☐	☐	☐
Pushing	☐	☐	☐
Pulling	☐	☐	☐
Walking	☐	☐	☐
Standing	☐	☐	☐
Twisting	☐	☐	☐
Turning	☐	☐	☐
Stretching	☐	☐	☐
Kneeling	☐	☐	☐
Climbing	☐	☐	☐
Above Shoulder Lifts	☐	☐	☐
Overhead Lifts	☐	☐	☐
Operation of Motorized Vehicle/Equipment /Machinery	☐	☐	☐

OTHER SPECIAL RESTRICTIONS:

☐ **3. These restrictions are in effect until _____ or until patient is re-evaluated on _____.**

☐ **4. These restrictions are PERMANENT.**

☐ **5. Patient is physically unable to return to work at this time. Patient will be re-evaluated on _____.**

Physician's Signature:	**Date:**

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize my attending doctor to release any information or copies thereof acquired in the course of my examination or treatment for the illness/injury identified above to my employer or representative.

Patient's Signature:	**Date:**

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ATTACHMENT G

Form 114 **KENTUCKY OFFICE OF WORKERS CLAIMS**
657 Chamberlin Ave
Frankfort, Kentucky 40601

REQUEST FOR PAYMENT FOR SERVICES OR REIMBURSEMENT FOR COMPENSABLE EXPENSES
TO BE FILED WITH THE RESPONSIBLE EMPLOYER OR ITS PAYMENT OBLIGOR

1) Name, address and Workers Compensation claim number of Employee for whom services were provided or expense incurred: _____
_____

2) Specific type and dates of service(s) provided:
_____

Dates:	**Type of Service(s)**

3) Name and address of physician who ordered services: (include written authorization if available)
_____

4) Reasonable value of services, including method of computation: $ _____ : _____
_____

5) Other expenses incurred for cure or relief of a work injury or occupational disease(s):
_____

Dates:	**Description of Expense(s)**	**$ Amount**	**If mileage, number of miles**
	Total	$	Miles:

Please attach receipts for all purchased items

Certification:

I hereby certify that the above services were performed or expenses were incurred for the cure or relief of a work injury or occupational disease sustained by the above employee.

Witness: _____ _____
(Name of Person requesting payment)

Date:_____ Address: _____

Phone no: _____

NOTICE:

Any person who knowingly and with intent to defraud any insurance company or other person files a statement or claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Form AWW-1
Average Weekly Wage Certification
Adopted January 1, 1997

ATTACHMENT H

KENTUCKY
DEPARTMENT OF WORKERS CLAIMS

CLAIM NUMBER _____

_____ **PLAINTIFF**

VS **WAGE CERTIFICATION**

_____ **DEFENDANTS**

---

1. Date of Injury/Exposure as reported on Form 101/102/103: _____

2. Method of Wage Payment (check one):

☐ Hourly ☐ Daily

☐ Weekly Salary ☐ Monthly Salary

☐ Yearly Salary ☐ Output of Employee

3. Date of Hire or Employment: _____

4. Status or Classification of Employment (check one):

☐ Part-time ☐ Full-time ☐ Probationary

☐ Seasonal ☐ Volunteer ☐ Apprentice/Trainee

5. Did Employer provide any of the following (check appropriate ones):

☐ Board ☐ Rent ☐ Housing

☐ Lodging ☐ Fuel

6. Did Employee (check appropriate ones):

☐ Work Overtime ☐ Receive Gratuities ☐ Paid Vacations/Holidays

ATTACHMENT H-1

Claimant's Name: _____

Claim Number: _____

Weeks Worked Month/Day/Year	**# of Regular Hours Worked**		**# of Overtime Hours Worked**		**Regular Hourly Rate**		**Weekly Wage**
1.	_____	+	_____	x	_____	=	_____
2.	_____	+	_____	x	_____	=	_____
3.	_____	+	_____	x	_____	=	_____
4.	_____	+	_____	x	_____	=	_____
5.	_____	+	_____	x	_____	=	_____
6.	_____	+	_____	x	_____	=	_____
7.	_____	+	_____	x	_____	=	_____
8.	_____	+	_____	x	_____	=	_____
9.	_____	+	_____	x	_____	=	_____
10.	_____	+	_____	x	_____	=	_____
11.	_____	+	_____	x	_____	=	_____
12.	_____	+	_____	x	_____	=	_____
13.	_____	+	_____	x	_____	=	_____
					Total:		$ _____
					÷ By 13 weeks		
					=		$ _____
14.	_____	+	_____	x	_____	=	_____
15.	_____	+	_____	x	_____	=	_____
16.	_____	+	_____	x	_____	=	_____
17.	_____	+	_____	x	_____	=	_____
18.	_____	+	_____	x	_____	=	_____
19.	_____	+	_____	x	_____	=	_____
20.	_____	+	_____	x	_____	=	_____
21.	_____	+	_____	x	_____	=	_____
22.	_____	+	_____	x	_____	=	_____
23.	_____	+	_____	x	_____	=	_____
24.	_____	+	_____	x	_____	=	_____
25.	_____	+	_____	x	_____	=	_____
26.	_____	+	_____	x	_____	=	_____
					Total:		$ _____
					÷ By 13 weeks		
					=		$ _____

ATTACHMENT H-2

Claimant's Name: _____

Claim Number: _____

Weeks Worked Month/Day/Year	**# of Regular Hours Worked**		**# of Overtime Hours Worked**		**Regular Hourly Rate**		**Weekly Wage**
27.	_____	+	_____	x	_____	=	_____
28.	_____	+	_____	x	_____	=	_____
29.	_____	+	_____	x	_____	=	_____
30.	_____	+	_____	x	_____	=	_____
31.	_____	+	_____	x	_____	=	_____
32.	_____	+	_____	x	_____	=	_____
33.	_____	+	_____	x	_____	=	_____
34.	_____	+	_____	x	_____	=	_____
35.	_____	+	_____	x	_____	=	_____
36.	_____	+	_____	x	_____	=	_____
37.	_____	+	_____	x	_____	=	_____
38.	_____	+	_____	x	_____	=	_____
39.	_____	+	_____	x	_____	=	_____
					Total:		$ _____
					÷ By 13 weeks		
					=		$ _____
40.	_____	+	_____	x	_____	=	_____
41.	_____	+	_____	x	_____	=	_____
42.	_____	+	_____	x	_____	=	_____
43.	_____	+	_____	x	_____	=	_____
44.	_____	+	_____	x	_____	=	_____
45.	_____	+	_____	x	_____	=	_____
46.	_____	+	_____	x	_____	=	_____
47.	_____	+	_____	x	_____	=	_____
48.	_____	+	_____	x	_____	=	_____
49.	_____	+	_____	x	_____	=	_____
50.	_____	+	_____	x	_____	=	_____
51.	_____	+	_____	x	_____	=	_____
52.	_____	+	_____	x	_____	=	_____
					Total:		$ _____
					÷ By 13 weeks		
					=		$ _____

ATTACHMENT H-3

CERTIFICATION

I hereby certify that the above wage information is a true and accurate accounting of the wages of (claimant's name) _____ from the date of employment or fifty-two weeks prior to the date of the injury/last exposure as set forth in the Form 101/102/103, whichever is shorter.

_____

Name of Company

_____

Signature

_____

Title

_____

Date

CERTIFICATE

It is hereby certified that the original of this wage certification was mailed this _____ day of _____, 199__ to the Commissioner and a copy of the same to Counsel of record and the assigned Administrative Law Judge.

_____

Attorney for Defendant Employer

ATTACHMENT I

Form 113
Designation of Physician
Revised 03-12-03

Two-Sided Form

COMMONWEALTH OF KENTUCKY
DEPARTMENT OF WORKERS' CLAIMS
657 TO BE ANNOUNCED AVENUE
FRANKFORT, KY 40601
Claim No. _____

NOTICE OF DESIGNATED PHYSICIAN

EMPLOYEE: _____
Name

_____
Street Address

_____ ( ) _____
City, State, Zip Telephone Number

_____ _____
Date of Birth Social Security Number

EMPLOYER AT TIME OF INJURY OR LAST EXPOSURE:

_____
Name

_____
Street Address

_____
City, State, Zip

NATURE OF INJURY OR OCCUPATIONAL DISEASE: _____

DATE OF INJURY OR LAST EXPOSURE: _____

FIRST DESIGNATED PHYSICIAN:

_____
Name

_____
Street Address

_____ ( ) _____
City, State, Zip Telephone Number

Accepted by: _____

MEDICAL INFORMATION RELEASE: I hereby waive any privilege I may have to restrict the release of information or written material reasonably related to the work-related injury/disease for which I have sought treatment, and I consent to the release of this information or written material to the medical payment obligor, my employer, Special Fund, Uninsured Employers' Fund, or attorneys representing me or any of the parties named above.

_____ _____
Date Employee Signature

MEDICAL PAYMENT OBLIGOR:

_____
Name Of Obligor

_____
Representative

_____
Street Address

_____ ( ) _____
City, State, Zip Telephone Number

Notice: The Workers' Compensation Act requires the employer to pay for the medical services reasonably necessary for cure and relief from the effects of a workplace injury or disease.

The employee may choose the physician (including chiropractors, etc.) who treats him as "designated physician." The designated physician is responsible for the coordination of the employee's medical care and may refer the patient to consulting or treating physicians as required. Except in an emergency, all treatment must be performed by or on referral from the designated physician. The employee may not change his designated physician more than once without the medical payment obligor's consent.

This form identifies the designated physician and must be returned to the medical payment obligor within ten (10) days after treatment begins. An identification card will be provided to the employee, and that card should be presented when medical treatment is required.

Inquiries shall be made to the listed representative of the medical payment obligor.

This form is not advance authorization from the workers' compensation medical payment obligor for medical services.

APPENDIX

DEFINITIONS

COMPENSABLE	Entitlement to benefits
COMPENSATION	Payment to injured worker or his/her dependents
DISABILITY	A decrease of wage earning capacity due to injury or loss of ability to compete to obtain the kind of work the employee is customarily able to do.
TEMPORARY TOTAL DISABILITY	Means the condition of an employee who has not reached *maximum medical improvement* from an injury and has not reached a level of improvement that would permit a return to employment.
INCOME BENEFITS	Payments made to the disabled worker or his dependents in case of death, excluding medical and related benefits.
INJURY	"Injury" means any work-related traumatic event or series of traumatic events including cumulative trauma, arising out of and in the course of employment which is the proximate cause producing a harmful change in the human organism evidenced by objective medical findings. "Injury" does not include the effects of the natural aging process, and does not include any communicable disease unless the risk of contracting the disease is increased by the nature of the employment. "Injury" when used generally, unless the context indicates otherwise, shall include an occupational disease and damage to a prosthetic appliance, but shall not include a psychological, psychiatric, or stress-related change in the human organism, unless it is a direct result of a physical injury.
OCCUPATIONAL DISEASE	Means a <u>disease</u> arising out of and in the course of the employment.
MEDICAL RELATED BENEFITS	Payments made for medical, hospital, burial and other services other than income benefits.
MEDICAL SERVICES	Medical, surgical, dental, hospital, nursing and medical rehabilitation services, medicines, and fittings for artificial or prosthetic devices
SELF-INSURER	An employer who has been authorized to carry his own liability on his employees.